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NO. 04-1506

IN THE SUPREME COURT OF THE UNITED STATES

ARKANSAS DEPARTMENT OF HUMAN SERVICES, ET AL.,

Petitioners,

v.

HEIDI AHLBORN,

Respondent.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

AMICUS CURIAE BRIEF OF THE STATES OF WASHINGTON, ALASKA, ARIZONA, COLORADO, CONNECTICUT, DISTRICT OF COLUMBIA, GEORGIA, HAWAII, IDAHO, ILLINOIS, KANSAS, KENTUCKY, MAINE, MARYLAND, MASSACHUSETTS, MICHIGAN, MISSOURI, MONTANA, NEW HAMPSHIRE, NEW JERSEY, NEW YORK, NORTH DAKOTA, OHIO, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, UTAH, WISCONSIN, AND WYOMING IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Whether federal Medicaid law, which requires that a medical assistance recipient assign to the state any right to payment from a third party who is liable for the recipient's medical expenses and which also prohibits the placement of a pre-death lien upon a recipient's "property", entitles the state to full reimbursement from personal injury settlement proceeds of Medicaid benefits paid on the recipient's behalf, regardless of what portion of the settlement proceeds are designated as compensation for medical care.

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INTEREST OF AMICI

Washington and the other amici states have two substantial interests in the issue presented in this case.[1] First, the amici states have an interest in providing medical assistance to their low income residents who do not have other health care coverage. Toward that end, all of them participate in the federal Medicaid program pursuant to Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396v. Medicaid is "a cooperative endeavor in which the Federal Government provides financial assistance to participating States to aid them in furnishing health care to needy persons". *Harris v. McRae*, 448 U.S. 297, 308 (1980).

States are not required to participate in the Medicaid program, but a state that chooses to do so must submit a state Medicaid plan meeting the requirements specified in federal law for approval by the Department of Health & Human Services' Centers for Medicare & Medicaid Services (CMS)[2], the federal agency charged with administering the Medicaid program. In addition, a participating state must comply with all mandatory requirements in order to receive the federal reimbursement. Within the parameters outlined in federal law, states have considerable discretion in structuring their Medicaid program, but are subject to ongoing oversight by CMS, which can impose sanctions if it determines

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[1] This brief is submitted by the Attorneys General of the amici states pursuant to Rule 37.4.

[2] Prior to July 2001, CMS was known as the Health Care Financing Administration (HCFA). Some of the cases cited below refer to it by that name.

that a state's Medicaid program is not being administered consistent with the requirements of federal law.

Second, the amici states have an interest in operating their respective Medicaid programs in a cost-effective manner. More specifically, they have an interest in assuring that publicly-funded medical assistance is provided only when there is no other source from which the cost of such assistance can be paid. The federal government shares this interest and requires, as one of the conditions of federal reimbursement under the Medicaid program, that participating states' Medicaid plans include an assurance that state law requires Medicaid recipients assign to the state Medicaid agency the recipient's "rights . . . to payment for medical care from any third party". 42 U.S.C. § 1396k(a)(1)(A).[3] States also are required to assure that they actively pursue recovery of payments from such third parties. 42 U.S.C. § 1396a(a)(25)(B).

All amici states have adopted legislative provisions and established third party recovery

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[3] Third party liability for medical assistance can arise from a variety of circumstances. For example, a child who receives care may have a legally responsible parent whose identity or location was unknown at the time care was provided. Another example would be a person who had private insurance coverage, the existence of which was unknown at the time the medical assistance was provided. However, this case involves recovery of medical assistance costs incurred as the result of tortious conduct of third parties. This brief accordingly focuses exclusively on this category of third party recoveries.

programs to satisfy these requirements.[4] While the details of the various states' statutes vary somewhat, in general they include the following elements:

- Receipt of Medicaid-funded medical care by a recipient results in the automatic assignment to the state Medicaid agency[5] of the recipient's rights to recover the cost of such care from a responsible third party. *See, e.g.*, Wash. Rev. Code § 43.20B.060(1) .
- As assignee/subrogee, the state Medicaid agency has the right to proceed directly against the liable third party for recovery of the Medicaid expenditures. *See, e.g.*, Colo. Rev. Stat. § 26-4-403(3); Alaska Stat. § 47.05.070(b).
- The state Medicaid agency has a lien against the proceeds of any judgment against the third

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[4] The appendix includes a list of the amici states' respective statutes authorizing their state Medicaid agencies to pursue recovery of the cost of medical assistance provided to recipients under circumstances where a third party is liable to pay for the costs of such care. For all but a few of the amicii states, the appendix reflects the amount recovered for medical costs incurred because of tortious conduct of third parties during the most recent fiscal year for which information is available.

[5] One of the statutory requirements for participation in the Medicaid program is that the state must designate a "single State agency to administer or to supervise the administration of the plan". 42 U.S.C. § 1396a(a)(5). Each of the amici states have complied with that requirement. However, the names given to the agency vary among the states. Therefore, in this brief, the "single state agency" will be referred to as the "state Medicaid agency".

party, or any settlement entered into between the recipient and the third party, to the extent of the cost paid by the state Medicaid agency for the medical assistance provided.[6] *See, e.g.*, N.Y. Soc. Serv. Law § 104-b; Mont. Code § 53-2-612.

Pursuant to 42 U.S.C. § 1396k(b), the federal government shares in these recoveries to the extent of its financial contributions to the states' Medicaid program, which means that between fifty and eighty-three percent of the amounts recovered are reimbursed to the federal government.[7]

The decision below adversely affects the states' interests in providing medical assistance to low income citizens in a cost effective manner. In the case at bar, *Ahlborn v. Arkansas Department of Human Services*, 397 F.3d 620 (8th Cir. 2005), the Eighth Circuit reversed the District Court[8] and held that Arkansas could effect a recovery of medical

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[6] Some states' statutes provide that the lien arises automatically upon the provision of the medical assistance. *See, e.g.*, Colo. Rev. Stat. § 26-4-403(4)(a). Others require an affirmative act, such as filing the lien in public records, in order for the lien to be effective. *See, e.g.*, Wash. Rev. Code § 43.20B.050(2). Finally, some of the amici states' statutes do not specifically create a lien on third party recoveries, but do specify that recovery of the full amount of Medicaid expenditures have priority over other claims against any settlement or judgment. *See, e.g.*, S.C. Code § 43-7-440(D).

[7] The amount of federal contribution to a state's Medicaid program varies between fifty and eighty-three percent. 42 C.F.R. § 433.10.

[8] *Ahlborn v. Arkansas Dep't of Human Servs.*, 280 F. Supp. 2d 881 (E.D. Ark. 2003).

assistance only from that portion of a settlement between a Medicaid recipient and the alleged tortfeasor that represented recovery of medical care costs, rather than the entire settlement.

The Eighth Circuit's holding was predicated on the court's conclusion that a state-created lien designed to effectuate the assignment required by 42 U.S.C. § 1396k(a)(1)(A) and comply with the state's obligation under 42 U.S.C. § 1396a(a)(25)(B) cannot be applied to the portion of the settlement intended to compensate the recipient for losses other than the cost of medical care. This is so, according to the Eighth Circuit, because of the language in 42 U.S.C. § 1396p(a)(1), which bars a state from imposing a lien "against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan" (with certain exceptions irrelevant to this case).

If allowed to stand, this interpretation will adversely affect the interests of the amici states in at least two significant ways. First, and most important, the decision below will reduce the amount amici states recover from third party tortfeasors. Because most personal injury claims are settled, often without initiating litigation, it will be the very rare exception that a state will be able to demonstrate that the settlement amount includes full recovery of its Medicaid expenditures on behalf of the injured party. Accordingly, the amounts of recoveries that states are able to obtain will necessarily decline significantly. The reduction in recoveries that results from the Eighth Circuit's decision will in turn reduce the financial resources

available to the states to provide medical assistance to their citizens, or require that states divert their finite resources from other worthwhile public purposes to make up the difference.

The *Ahlborn* case illustrates the extent of reduced recoveries likely to result from the Eighth Circuit's decision. Ms. Ahlborn was injured in an automobile collision and, as a result, incurred significant injuries, the treatment for which was paid by the Arkansas Medicaid program at a cost of $215,645.30. *Ahlborn*, 397 F.3d at 622. She unilaterally reached a settlement with her own uninsured motorist insurance carrier and with the liability insurance carriers for the parties who allegedly were responsible for causing the collision in the total amount of $550,000. The settlement amount was sufficient to reimburse the Arkansas Medicaid agency completely and leave a significant balance to be divided between Ms. Ahlborn and her attorney. Yet, under the holding of the Eighth Circuit, if allowed to stand, Arkansas' Medicaid agency will recover from this settlement or judgment not the amount of its expenditures, but only "to the extent that a settlement or award constitutes payment by the third party for medical expenses incurred by the recipient". *Ahlborn*, 397 F.3d at 625.

Ms. Ahlborn and the Arkansas Medicaid agency reached a stipulation that apportioned $35,581.47 of the $550,000 settlement as "a fair representation of the percentage of the settlement constituting payment by the tortfeasor for past medical care". *Ahlborn*, 397 F.3d at 622. The basis for computing this amount—which represents approximately sixteen-point-five percent of the total

Medicaid expenditure on Ms. Ahlborn's behalf—is not explained in either the Eighth Circuit decision or the District Court decision that preceded it.

Moreover, in this regard, the *Ahlborn* case is almost assuredly the exception, not the rule. In most situations, it will be unlikely that such agreements will easily be reached. As the Georgia Supreme Court observed in announcing a contrary holding, the approach subsequently adopted by the Eighth Circuit "would allow a Medicaid recipient to negotiate a tort settlement structured in such a way so as to reflect no, or minimal, compensation for medical expenses, or to convince a jury to create such structures, and thereby gain a recovery that does not require any significant compensation to the taxpayers who funded [the recipient's] medical care". *Richards v. State Dep't of Cmty. Health*, 604 S.E.2d 815, 818 (Ga. 2004). The Georgia Supreme Court concluded that this "would be blatantly unfair to those taxpayers". *Id.*

The second adverse impact on the amici states is that the decision below will inevitably increase administrative and legal costs that states will have to incur in pursuing third party recoveries. The Eighth Circuit opinion gave minimal significance to the difficulties of determining the proper amount of recovery under its ruling, suggesting that, in an individual case, recovery of more than the amount characterized by the parties as recovery of medical expenses "might be permissible because the third-party payment is properly recharacterized as a payment for medical expenses, despite a different label applied by the parties". *Ahlborn*, 397 F.3d. 627. This case-by-case approach is damaging because the

enormous difficulty of allocating a lump sum settlement among several potential damage components is a practical reality that will result in an inevitable increase in administrative and legal costs that states will have to incur in pursuing third party recoveries.

Under most of the amici states' current practices, the injured Medicaid recipient pursues the recovery from the tortfeasor. When a judgment or settlement has been achieved, the state Medicaid agency is able to assert its lien or statutory priority up to the total amount of the medical assistance provided and is often able to recover the full amount of its expenditures without requiring active intervention in the litigation by its legal counsel. The Eighth Circuit's decision, however, will force states to choose between two undesirable approaches: (1) deferring to the allocation decisions of the parties, who, as the District Court noted, have "no interest in placing an appropriate value on that component of recovery" (*Ahlborn*, 280 F. Supp. 2d at 888), or (2) actively intervening in the litigation in every instance to protect their interest in maximizing recoveries.

The experience of the State of Minnesota is illustrative of both the reduction of recovery from third party tortfeasors and the increase in administrative and legal costs. Information from the Minnesota Medicaid agency indicates that prior to the decision of the Minnesota Supreme Court in *Martin ex rel. Hoff v. City of Rochester*, 642 N.W.2d 1 (Minn. 2002), the agency relied primarily on its statutory lien under Minn. Stat. § 256B.042 to recover Medicaid expenditures from the proceeds of recipients' tort settlements. Pursuant to that

statute, Medicaid recipients were required to notify the department upon any settlement of claims against liable third parties. The department would then apply the formula set forth in the lien statute to determine what portion of the settlement must go to reimburse Medicaid expenditures. This is typical of the manner in which most amici states currently effectuate third party recoveries.

The *Martin* decision altered this process by striking down Minnesota's lien statute on the same basis underlying the Eighth Circuit's decision in the case at bar, i.e., that the Minnesota lien statute impermissibly attached to non-medical claims that the recipient was not required to assign as a condition of Medicaid eligibility under federal law contrary to 42 U.S.C. § 1396p.[9] The *Martin* court also interpreted the assignment statute narrowly—as applicable only to claims or proceeds for medical expenditures. Since *Martin*, Minnesota's Medicaid agency no longer is able to rely on its lien to recover

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[9] Other than the Eighth Circuit below and the *Martin* court, all other appellate courts that have addressed the issue have concluded that application of the state Medicaid agency's lien or other statutory priority to the entire settlement or judgment does not violate the anti-lien statute, because the federally required assignment transfers the entire cause of action to the state. *See Richards v. State Dep't of Cmty. Health*, 604 S.E.2d 815 (Ga. 2004); *Nacino v. Koller*, 71 P.3d 417 (Hawaii 2003); *Houghton v. Dep't of Health*, 57 P.3d 1067 (Utah 2002); *Grey Bear v. State Dep't of Human Servs.*, 651 N.W.2d 611 (N.D. 2002); *Wilson v. State*, 10 P.3d 1061 (Wash. 2000); *Calvanese v. Calvenese*, 710 N.E.2d 1079 (N.Y. 1999); *Cricchio v. Pennisi*, 683 N.E.2d 301 (N.Y. 1997); *Walker v. District of Columbia*, 682 A.2d 639 (D.C. 1996); *Coplien v. Dep't of Health & Soc. Servs.*, 349 N.W.2d 92 (Wis. 1984).

its expenditures from third parties. Instead, it has been required to rely on the statutory assignment of medical claims pursuant to Minn. Stat. § 256B.056 and to take affirmative action to assert this reimbursement right. As a result, since *Martin*, Minnesota has more frequently been required to resolve third party tort actions by accepting less than a full recovery of its Medicaid expenditures.

Minnesota's collection costs have also increased. Since the *Martin* decision, the Minnesota Department of Human Services has referred 776 cases to the Minnesota Attorney General's Office. Of those cases, AG staff have intervened in ongoing litigation in 119 cases, obtained agreements from the recipient's counsel to represent the department in approximately 165 cases, and referred 33 cases to outside counsel for representation, resulting in an increase in the costs of legal representation in third party recovery actions the state is pursuing.

ARGUMENT

The anti-lien statute on which the Eighth Circuit decision turned provides that (with exceptions not pertinent here) "[n]o lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan". 42 U.S.C. § 1396p(a)(1). However, under the Arkansas statute, Ms. Ahlborn and other Medicaid recipients assigned their rights to "any settlement, judgment, or award which may be obtained against any third party to [the Arkansas Medicaid agency] to

the full extent of any amount which may be *paid by Medicaid* for the benefit of the applicant". Ark. Code § 20-77-307(a) (emphasis added).

Thus, as the District Court recognized, the only portion of Ms. Ahlborn's claim for reimbursement from the tortfeasor that remained her property was that amount exceeding the amount that Arkansas had paid for her medical care. *Ahlborn*, 280 F. Supp. 2d at 888 (quoting *Wallace v. Estate of Jackson*, 972 P.2d 446, 448 (Utah 1998)). As applied to Ms. Ahlborn, this means that only the difference between the total settlement amount of $550,000 and the Medicaid expenditures of $215,645.30 was her property. The assignment of her rights resulting from the application of the state assignment statue transferred any interest she had in the latter amount to the Arkansas Medicaid agency.

The Eighth Circuit's contrary conclusion fails to reconcile the pertinent statutes and is inconsistent with their legislative history. The anti-lien provision was intended to protect the assets of the aged, blind, and disabled individuals who had sufficient income and resources to meet their basic needs but not enough to pay increasingly higher medical costs.[10] In

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[10] The Medicaid Act generally defines two groups of needy persons that may be included in a state's Medicaid program—the categorically needy and the medically needy. 42 U.S.C. § 1396a(a)(10)(A), (C); 42 C.F.R. § 435.4. Generally speaking, the categorically needy group consists of those persons who, regardless of their age or medical condition, lack sufficient income or resources to meet basic needs, including routine medical care. The medically needy group that a state may choose to cover under Medicaid consists primarily (again,

contrast, the history of third party liability requirements demonstrates that Congress intended to make third parties pay whenever possible so that Medicaid was the payer of last resort. The Eighth Circuit had recognized this strong congressional intent seven years before its *Ahlborn* decision in *Norwest Bank of North Dakota v. Doth*, 159 F.3d 328 (8th Cir. 1998). In rejecting an argument that Minnesota's lien for Medicaid expenditures did not reach settlement proceeds placed in a special needs trust, the Eighth Circuit stated that to hold otherwise "would eviscerate Congress's clearly expressed intention that these funds be repaid and negate the Social Security Act's comprehensive scheme permitting states to place these liens". *Norwest Bank*, 159 F.3d at 333 (internal punctuation omitted).[11]

So strong is this policy that the federal government has sanctioned states for agreeing to accept less than the full amount of Medicaid expenditures from recipients' settlements with third party tortfeasors.

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generally speaking) of those aged, blind, or disabled individuals whose income and resources are sufficient to meet their daily needs, but not sufficient to cover the costs of extraordinary medical expenses, primarily long-term care. 42 U.S.C. § 1396a(a)(10)(C); 42 C.F.R. § 435.308.

[11] The *Norwest Bank* court specifically stated that it was not ruling on "whether the [state's] lien may be satisfied out of the entire amount of the personal injury award or settlement, or only that portion of the settlement attributable to past medical expenses". *Norwest Bank*, 159 F.3d at 334.

A. The Eighth Circuit Decision Fails To Reconcile Pertinent Statutes

The resolution of this case requires this Court to analyze the intersection of three statutes:

- 42 U.S.C. § 1396a(a)(25)(B) and (H), which require states to identify and actively pursue recovery from third party tortfeasors who are liable for medical expenses incurred by Medicaid recipients and to have in effect laws under which the state acquires the recipient's right to recover from a third party;
- 42 U.S.C. § 1396k, which requires states to ensure that Medicaid recipients assign any rights they have to recovery of medical expenses from third parties; and
- 42 U.S.C. § 1396p, which prohibits states from imposing liens "against the property of any individual prior to his death on account of medical assistance" (§ 1396p(a)) (with exceptions not relevant here) and further provides that "[n]o adjustment *or recovery* of any medical assistance correctly paid on behalf of an individual under the State plan may be made" (§ 1396p(b)(1)) (emphasis added).

On the face of these provisions, there appears to be a conflict between § 1396a(a)(25)(B) and (H) and § 1396k—requiring states to secure assignment of rights to recover payment for medical costs and to vigorously pursue such recovery—and § 1396p—prohibiting both imposition of liens against "property" of a recipient and "recovery" of medical

assistance "correctly paid".[12] In resolving seeming conflicts, this Court should "examine first the language of the governing statute, guided not by a single sentence or member of a sentence, but looking to the provisions of the whole law, and to its object and policy". *John Hancock Mutual Life Ins. Co. v. Harris Trust & Savings Bank*, 510 U.S. 86, 94-95 (1993) (internal punctuation omitted).

This is particularly true with respect to the Medicaid provisions of the Social Security Act, which this Court has agreed "is among the most intricate ever drafted by Congress [with a] Byzantine construction [that] makes the Act almost unintelligible to the uninitiated". *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981) (quoting Judge Friendly in *Friedman v. Berger*, 547 F.2d 724, 727 n.7 (2d Cir. 1976)).

The Eighth Circuit did not adopt this Court's approach; rather, it simply held that the state's recovery efforts must yield to the anti-lien provisions without any consideration of either the object or policy of any of the three sections of the Medicaid Act implicated in this case. Had the court below adhered to this Court's guidance quoted above, it would have read the three provisions in a manner that gives maximum effect to, and accomplishes the policy objectives of, each of the three sections.

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[12] In the case at bar, there is no dispute that medical assistance was "correctly paid" on behalf of Ms. Ahlborn.

B. Legislative History Demonstrates That The Anti-Lien Provision Was Not Intended To Take Precedence Over Third Party Recoveries From Tortfeasors

1. Legislative History Of Anti-Lien Provision

The anti-lien provision of the Medicaid Act had its genesis in the 1960 amendments to the Social Security Act that created the predecessor to the Medicaid program. Prior to the enactment of these amendments, the federal government participated financially in programs under which some, but not all, states provided "old age assistance" for needy persons over 65 years of age, i.e., those lacking sufficient income or resources to meet their basic needs. These programs, like Medicaid, were optional with the states. The amount and scope of assistance they provided, and the manner in which it was provided, varied greatly among the states.[13]

The 1960 amendments to the Social Security Act provided an increased level of federal support for the existing old age assistance programs for the needy. In addition, they authorized a new state-federal partnership, known informally as the Kerr-Mills program. Under this program, the federal government offered incentives to states to provide medical assistance to persons over the age of 65 who were not eligible for "old age assistance" because they had sufficient income for their basic needs, but

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[13] For a more detailed outline of the nature of medical assistance provided and the manner in which it was distributed by the various states, see 1960 U.S.C.C.A.N. at 3730-41.

lacked sufficient resources to meet increasingly higher medical care costs. The Senate Finance Committee Report accompanying the legislation explained:

> "The major issue presented to the committee this year has been the increasing cost of adequate medical care for older people. The evidence presented to the committee indicated that these costs derive, to a large extent, from the fact that impressive improvements have been made in medicines and medical technology, which assist in better diagnosis and treatment, and from improved hospital and other facilities and their wider availability to the public. . . .
>
> "As a result, we are recommending a program of federal assistance in providing, through the cooperation of the states, an expanded program of medical care for persons aged 65 and over. Under this proposal the federal share of existing old-age assistance plans will be substantially increased to encourage states to strengthen their medical programs for these people or to initiate new programs. In addition, federal money will be made available, on a generous matching formula, to assist the states in aiding those aged persons, many of them otherwise self-sufficient, who need help only in meeting the cots of medical care of a very expensive nature." S. Rep. No. 86-1856 (1960), *reprinted in* 1960 U.S.C.C.A.N. 3608, 3609.

In addition to the increased federal funding, the legislation was also generous in allowing states to disregard a recipient's resources in determining eligibility. The report describes the changes:

> "Under this program, it will be possible for states to provide medical services to individuals on the basis of an eligibility requirement that is more liberal than that in effect for the States' old-age assistance programs.
>
> ". . . .
>
> "A state may, if it wishes, disregard in whole or in part, the existence of any income or resources, of an individual for medical assistance. . . .
>
> "This is based on the grounds that an aged individual who has adjusted his living standard to a low income, but who still has income and resources above the level applicable for old-age assistance, might be unable to deal with his medical expenses." S. Rep. No. 86-1856 (1960), *reprinted in* 1960 U.S.C.C.A.N. at 3613-14.[14]

As with the current Medicaid Act, those states that chose to participate in the Kerr-Mills program were required to submit a state plan specifying the scope of medical assistance offered and meet certain statutory requirements, which included the following:

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[14] Although not denominated as such, this group is the antecedent to the "medically needy" group of recipients that states have the option to include in their Medicaid programs under current law. *See* note 10 *supra* p. 11-12.

> "*[I]f the State plan includes medical assistance for the aged* [it must] provide that no lien may be imposed against the property of any individual prior to his death on account of medical assistance for the aged paid or to be paid on his behalf under the plan . . . and that there shall be no adjustment or recovery (except, after the death of such individual and his surviving spouse, if any, from such individual's estate) of any medical assistance for the aged correctly paid on behalf of such individual under the plan." Pub. L. No. 86-778, § 601(b) (Sept. 13, 1960) (emphasis added) (adding § 2(a)(11)(E) to the Social Security Act).

The reason for conditioning this requirement on a state's decision to include medical assistance in addition to old-age assistance in its program is apparent from the context. Recipients of old-age assistance for the needy, by definition, had little by way of resources and, thus, had no property against which a state could assert a lien. However, with the expanded coverage to those that, in current Medicaid parlance, would be considered "medically needy", and who may have significant resources, particularly in the form of a residence, a state's incentive to assert such a lien would be greater.

Likewise, the purpose for inserting the anti-lien provision is apparent from the context. Without the foregoing language, elderly couples who owned their own homes would be required to sell them and use the proceeds to pay for their own care before becoming eligible for the new program. The anti-lien

provision was designed to prevent that from occurring, as described in the Senate report.

> "Although the requirements for the approval of the medical assistance for the aged in the state plan are generally comparable to those in the public assistance titles of the Social Security Act, the committee concluded that some changes are needed to carry out the intent of the new part of the program.
>
> "A state would not be permitted as a condition for medical assistance to impose a lien on the property of a recipient during his lifetime. . . . However, the bill would permit the recovery from an individual's estate after the death of his spouse if one survives him. *This provision was inserted in order to protect the individual and his spouse from the loss of their property, usually the home, during their lifetime.*" S. Rep. No. 86-1856 (1960), *reprinted in* 1960 U.S.C.C.A.N. 3608, 3615 (emphasis added).[15]

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[15] In addition to the beneficent aspects of the congressional policy reflected in this provision, allowing elderly couples to retain ownership of their residences during their lifetime also had a desirable practical effect. The contrary approach—de facto requiring an elderly person who needed extensive medical assistance to liquidate his or her residence before receiving any assistance—would, in many instances, create an even greater burden on the social welfare system, as persons needing medical care and others dependent upon them would ultimately come to rely on government support. Allowing recovery of the costs of medical assistance from the estate of the recipient *after* the death of the spouse and any dependent children allowed the family to remain in their home as long as possible, in many instances reducing public

Thus, from the outset, the purpose of the anti-lien statute was focused on recovery from the estates of the elderly who had received medical assistance and had nothing to do with recoveries from third parties of medical assistance provided because of their tortious conduct.

When the Medicaid program was created in 1965, the anti-lien language was retained, and the focus on assistance to the aged remained intact. The report accompanying that legislation explained:

> "[The current provisions of the Social Security Act] authorizing the medical assistance for the aged program now provide that the States may not impose a lien against the property of any individual prior to his death on account of medical assistance payments [with exceptions not pertinent here] and prohibit adjustment or recovery for amounts correctly paid except from the estate of an aged person after his death and that of his surviving spouse. This provision, under the committee bill, has been broadened so that such an adjustment or recovery would be made only at a time when there is no surviving child who is under the age of 21 or who is blind or permanently and totally disabled." S. Rep. No. 89-404 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 2020.

Though the scope of the anti-lien provision was "broadened" to protect a deceased recipient's

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assistance expenditures, and ultimately allowed taxpayers to recover the costs that were incurred.

dependents in addition to the surviving spouse, there is no indication in the legislative record that Congress intended to broaden the purpose of the statutory language beyond that described in the Senate report that described the initial legislation.

Further evidence that the anti-lien statute's focus was on estate recovery from the elderly is demonstrated by the Tax Equity & Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. No. 97-248 (Aug. 19, 1982), which amended the anti-lien provision and the related "look-back" provision which allowed states to deny eligibility for medical assistance to an otherwise eligible applicant who had transferred assets for less than full value during the 24 months preceding the application. Because the Medicaid Act as it existed at the time did not consider an applicant's home as a resource, "an elderly individual who anticipates needing nursing home care [could] give his/her home to a family member or friend without fear of losing or being denied Medicaid eligibility [and] by so doing [assure] that the home will not be part of his/her estate and therefore will not be subject to any recovery action initiated by the state after the individual's death". S. Rep. No. 97-494 (1982), *reprinted in* 1982 U.S.C.C.A.N. 781, 814.

To address this situation, the report explained, the legislation amended Title XIX in two particulars. The first authorized states to deny eligibility to an applicant for Medicaid who had disposed of his or her home. The second effect of the amendment was described as follows:

> "Second, the amendment would allow states to attach the real property, including the home, of Medicaid recipients who are permanently institutionalized in nursing homes or other long term care medical institutions. The lien could not be foreclosed upon, and states could recover the costs of medical assistance provided to the recipient only when the recipient voluntarily chose to sell the property or, after the recipient's death, from his estate. As under current law, no recovery would be permitted while the recipient's spouse was still living or while his/her children were still dependent (under 21, or blind, or disabled)." S. Rep. No. 97-494 (1982), *reprinted in* 1982 U.S.C.C.A.N. 781, 814-15.

The report described the purpose of the amendment as "facilitat[ing] States' efforts to recover medical assistance costs from these types of resources and to assure that all resources available to an individual will be used to defray the public costs of supporting that individual in a long-term medical institution". *Id.* at 815.

There is no suggestion in the legislative history of the anti-lien law that Congress considered the statute would have any application to any context other than that described above. More specifically, there was no indication that Congress perceived a conflict between the anti-lien law and the states' efforts to recover expenditures for medical assistance from third-party tortfeasors.

2. Legislative History Of Third Party Liability Requirements

By contrast, the legislative history of the Medicaid third party liability requirements demonstrates an increasingly strong Congressional policy that recoveries from third parties be maximized, consistent with the maxim that Medicaid is to be the payor of last resort. A requirement that states participating in Medicaid must identify potential third parties who might be liable to pay for the medical assistance provided was first added to the Medicaid Act in 1968. *See* Pub. L. No. 90-248, § 229 (Jan. 2, 1968) (adding new subsection to § 1902(a) of the Social Security Act). The Senate report described this requirement as follows:

> "It is obvious that many people need medical care because of an accident or illness for which someone else has fiscal liability; for example a health insurer or a party who is determined by a court to have legal liability. In order to make certain that the State and the Federal Governments will receive proper reimbursement for medical assistance paid to an eligible person when such third-party liability exists, a new requirement would be included in title XIX. Under this provision, the State or local agency would have to take all reasonable measures to ascertain the legal liabilities of third parties to pay for covered services. Where the legal liability is known it would be treated as a resource of the recipient. In addition, if medical assistance is granted and legal liability of a third party is established later, the State or local agency

> must seek reimbursement from such party. The Federal Government would, of course, recover its share of any reimbursement received." S. Rep. No. 90-744 (1967), *reprinted in* 1967 U.S.C.C.A.N. 2834, 3039.

In 1977, Congress strengthened the ability of states to identify and collect from third parties liable because of tortious conduct, or on some other basis, by granting permission to states to require an assignment by Medicaid recipients of medical support and/or indemnification to the state as a condition of eligibility. *See* Pub. L. No. 95-142, §12(b) (Oct. 25, 1977) (adding new § 1912 to the Social Security Act). This permissive approach was made mandatory in 1984 with the enactment of the Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2367(a) (July 18, 1984) (adding new subsection to § 1902 of the Social Security Act) and § 2367(b) (amending § 1912(a) of the Social Security Act).

These provisions were strengthened again by the enactment of the Comprehensive Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-272 (Apr. 7, 1986), which added various provisions to enhance states' efforts to recover medical assistance payments made to recipients for which third parties are liable. As the Senate report explained:

> "Medicaid is intended to be the payer of last resort, that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." S. Rep. No. 99-146 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 279.

In 1993, Congress further amended the section of the Social Security Act that includes the anti-lien provision to mandate that states pursue recoveries from the estates of recipients who were either permanently institutionalized or, after age 55, received "nursing facility services, home and community based services, and related hospital and prescription drug services". Pub. L. No. 103-66, § 13612 (Aug. 10, 1993) (amending § 1917(b)(1) of the Social Security Act). The amendment authorized states to identify in their state plans additional services that would be subject to estate recovery. *Id.*

In the same legislation, Congress amended the third party recovery sections of Title XIX of the Social Security Act to require further strengthening of the states' third party recovery. Specifically, state Medicaid plans must now include the following:

> "[T]o the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State [must have] in effect laws under which, *to the extent that payment has been made* under the State plan for medical assistance . . . furnished to an individual, the State *is considered to have acquired the rights of such individual to payment by any other party* for such health care items or services." Pub. L. No. 103-66, § 13622(c) (Aug. 10, 1993) (emphasis added) (adding subsection (I) to § 1902(a)(25) of the Social Security Act).

There is nothing in these 1993 amendments to the section of the Social Security Act that includes

the anti-lien provision or the sections dealing with third party recoveries that suggest Congress perceived a conflict between the two. Indeed, there is no conflict between the two because both are designed ultimately to achieve the same result, i.e., to enable states to provide medical assistance to qualified recipients and later recover the costs expended from the state and federal treasuries in so doing. The Eighth Circuit's decision concluded that there is a conflict and, in the process of resolving it, eliminated a significant tool used by states to assure that they are "considered to have acquired the rights of such individual to payment by [another] party". Pub. L. No. 103-66, § 13622(c) (Aug. 10, 1993). The decision below is contrary to the congressional policy evident in the Medicaid Act and in its legislative history, and should be reversed.

3. This Court Should Honor Congress' Intent And Reconcile The Statutes To Allow States To Continue Their Recovery Practices

As the legislative history demonstrates, this case lies at the intersection of two strong congressional policies: the first protects the homes of medically needy persons requiring long-term care, yet allows the taxpayers to eventually recover the costs of care from their estates; the second requires states to maximize their recovery of medical assistance necessitated by the tortious conduct of third parties. These policies do not conflict with each other. They share the common theme of minimizing the expenditure of public funds for individual medical care when other resources are or may become available.

The Eighth Circuit's decision frustrates the intent of Congress by limiting the states' recoveries to an amount that, in most cases, will be less than the amount of assistance provided. The District Court's decision—and that of every other court, save one, that have considered the issue—furthers the congressional intent to maximize recoveries without, in any manner, hindering the intent underlying the anti-lien statute. This Court should do likewise by reversing the Court of Appeals and remanding this matter with instructions to affirm the District Court's decision.

C. Congressional Policy In An Analogous Context Supports The States' Practices Of Seeking Full Recovery From Medicaid Recipients

The instant case deals with medical care paid for in part by the federal government and the states' ability to recover both the state and federal portion of the costs incurred in appropriate instances. This is not the only context under which the federal government seeks to recoup the costs of medical care for which it either pays or provides directly.

The federal government provides health care to certain military and civilian personnel and their families. *See, e.g.*, 10 U.S.C. § 1071-1104 (authorizing medical and dental benefits for members of the armed forces and their families). When the necessity for medical care provided by a federal agency arises out of the tortious conduct of a third party, the federal Medical Care Recovery Act (MCRA) gives the federal government a right of action against the tortfeasor for "the reasonable value of the care and

treatment so furnished, to be furnished, paid for, or to be paid for". 42 U.S.C. § 2651(a).

Unlike the Medicaid third party recovery statutes, the MCRA includes an explicit provision authorizing the federal agency to either compromise its claim for recovery of medical costs or waive the claim "in whole or in part" subject to regulations promulgated by the Department of Justice.[16] 42 U.S.C. § 2562(b). As the Senate report that accompanied this legislative enactment to the MCRA explained: "[I]t is not intended that this legislation should be used to recover Federal hospital and medical costs when the total recovery possible is insufficient, under all the circumstances, to provide fair and adequate compensation to the injured person for his own losses". S. Rep. No. 1945 (1962), *reprinted in* 1962 U.S.C.C.A.N. 2637, 2642.

The only condition precedent to a waiver under the MCRA is a determination by the agency head or designee that (1) doing so is in the best interest of the government or (2) that collection of the government's claim "would result in undue hardship upon the person who suffered the injury or disease resulting in care or treatment." 42 U.S.C. § 2562(b). Significantly, also unlike the Medicaid

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[16] The MCRA authorizes the President to promulgate implementing regulations, authority that the President has delegated to the Attorney General. Exec. Order No. 11060, 27 Fed. Reg. 10,925 (Nov. 7, 1962). The regulations may be found at 28 C.F.R. Part 43. Speaking generally, they provide that the agency which provided or paid for the care may compromise or waive any claim that does not exceed $100,000 and require Department of Justice approval for compromise or waiver of claims for larger sums.

third party recovery provisions, the MCRA specifically directs that no actions taken in its enforcement "shall operate to deny to the injured person the recovery for that portion of his damage not covered hereunder". 42 U.S.C. § 2652(c).

Presumably because of the lack of such language in the Medicaid third party recovery provisions, the federal agency responsible for overseeing state Medicaid programs has imposed sanctions against at least two states for having agreed to accept less than the full amount of Medicaid expenditures from recipients' settlements with third party tortfeasors. *California Dep't of Health Servs.*, D.A.B. No. 1504, 1995 WL 66334 (H.H.S. Jan. 5, 1995); *Washington Dep't of Soc. & Health Servs.*, D.A.B. No. 1561, 1996 WL 157123 (H.H.S. Feb. 7, 1996). In both of these cases, the state agencies had done what the MCRA explicitly would have allowed—compromise third party recovery claims for less than the amount of medical costs incurred. In both instances, the Health Care Financing Administration (HCFA), now known as CMS, required the states to reimburse the federal government for the full amount of federal funds that would have been recovered except for the state's compromise, a position that was upheld by the departmental appeals board.[17] This approach was consistent with HCFA policy statements dating back

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[17] In No. 1561, the Department of Health & Human Services Appeals Board upheld the provisions of the Washington statute providing that the state's Medicaid recovery from a settlement or judgment is to be reduced by a pro rata share of the recipient's attorney fees incurred in resolving the claim.

as far as 1988. J.A. at 27-41 (Ex. 3, 21, 22, discussed at *Ahlborn*, 280 F. Supp. 887).

The explicit language of the MCRA and its implementing regulations, together with the legislative history, demonstrate that when Congress wants to authorize the compromise of the recovery of publicly funded medical care, it says so explicitly. The lack of similar language in the Medicaid Act, combined with the strong language mandating full recovery of costs from liable third party tortfeasors, indicates a contrary intent in the Medicaid context.

In short, the Eighth Circuit's decision is inconsistent with the intent underlying the Medicaid Act, as evidenced by the language and legislative history of the pertinent statute and congressional expressions of contrary intent in an analogous context. The decision below should be reversed.

CONCLUSION

For the reasons set forth above, the Court of Appeals decision should be reversed and this matter remanded with directions to affirm the decision of the District Court.

RESPECTFULLY SUBMITTED.

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Appendix

State	Citation To State Statute	Annual Recoveries
Alaska	Alaska Stat. §§ 47.05.070, .075; 47.07.025	$1,356,716 (FY 2002)
Arizona	Ariz. Rev. Stat. Ann. §§ 36-2903(F), -2903.01(K), -2915, -2916; 12-962,	$10 million (estimate)
Colorado	Colo. Rev. Stat. § 26-4-403(3), (4), (5)	$3,072,421.49 (FY 2004-2005)
Connecticut	Conn. Gen. Stat. § 17b-265	$5.9 million (FY 04-05)
District of Columbia	D.C. Code §§ 4-601 to -607	(not available)
Georgia	Ga. Code Ann. §§ 49-4-140, -148(a), -149(a), -149(d), -157	$9,471,778
Hawaii	Haw. Rev. Stat. §§ 346-29(c), -37	$1-3 million (estimate)
Idaho	Idaho Code. Ann. § 56-209b	$1.6 million
Illinois	305 Ill. Comp. Stat. 5/11-22	$15,000,000 (estimate)

State	Citation To State Statute	Annual Recoveries
Kansas	Kan. Stat. Ann. § 39-719a	$1.7 million (estimate)
Kentucky	Ky. Rev. Stat. Ann. §§ 205.520, .624, .626, .628, .629	(not available)
Maine	Me. Rev. Stat. Ann. tit. 22, § 14	$5 million (estimate)
Maryland	Md. Code Ann. Health-Gen. §§ 15-120 to -121.3	(not available)
Massachu-setts	Mass. Gen. Laws ch. 118E, § 22; ch. 18, § 5G; ch. 152, § 46A	$10,685,590.86 (FY 2005)
Michigan	Mich. Comp. Laws § 400.106	$4 million
Missouri	Mo. Rev. Stat. §§ 208.2159, 287.266	$7,236,460.89
Montana	Mont. Code Ann. §§ 53-2-612, -613	$1,727,201 (FY 2004-2005)
New Hampshire	N.H. Rev. Stat. Ann. § 167:14-a	$1,152,313
New Jersey	N.J. Stat. Ann. §§ 30:4D-7(k), D-7.1	$9.3 million (estimate)
New York	N.Y. Soc. Serv. Law §§ 366(4)(h), 367-a(2)(b), 104-b	$4.5 million
North Dakota	N.D. Cent. Code § 50-24.1-02.1.	$608,234 (CY 2005 to present)

State	Citation To State Statute	Annual Recoveries
Ohio	Ohio Rev. Code Ann. § 5101.57-.59	$13,775,470.32
Oregon	Or. Rev. Stat. §§ 416.510 to .610	$3.5 million (estimate)
Rhode Island	R.I. Gen. Laws § 40-6-9	$3,104,974
South Carolina	S.C. Code Ann. §§ 43-7-410 to -440	$6.4 million (estimate)
South Dakota	S.D. Codified Laws § 28-6-7.1	$3,758,330 (FY 2004)
Utah	Utah Code Ann. §§ 26-19-1 to -19	$3,218,000 (estimate)
Washington	Wash. Rev. Code §§ 43.20B.050, .060, .070	$ 8,383,807 (FY 2005)
Wisconsin	Wis. Stat. § 49.89	$ 2.6 million (collected by State) 2.7 million (collected by counties) (FY 2005)
Wyoming	Wyo. Stat. Ann. § 41-2-201, -202, -203; 42-4-202, -203	(not available)